

WAIVER CANCELLATION REQUEST
GaUCHo Health Insurance (GHI)
2015-2016 Year

This form is to be used for requests to cancel health insurance waivers and, unless you lose your previous insurance coverage, may only be submitted during the fall quarter insurance enrollment period (see dates below.). If your waiver is cancelled, you will be enrolled in GaUCHo Health Insurance (GHI) and assessed the quarterly premium. The effective date of coverage will be the beginning of the current quarter.

If you are requesting to cancel your waiver after the enrollment period deadline due to loss of other insurance coverage, you must submit to this office documentation of loss of coverage from your previous insurance company. Your effective date of coverage will be the day following loss of other coverage. To cancel your waiver and enroll in GHI, proof of loss of coverage is required within 31 days of the qualifying life event (loss of coverage). For details on GHI, please access the Student Health website at <http://studenthealth.sa.ucsb.edu/gaUCHo-health-insurance/ghi-2015-2016>

Please return the completed form to an Insurance Advisor at Student Health Service or Fax to 805-893-5340.

MAIL: Insurance Advisor
Student Health Service
UC Santa Barbara
Santa Barbara, CA 93106

If you have questions, please call Insurance Services at 805-893-2592.

Please check the appropriate category, complete and sign this form:

CANCELLATION OF INSURANCE WAIVER

I wish to cancel my insurance waiver, effective:

	<u>Enrollment deadlines</u>
_____ Summer	June 23, 2015 (Teacher Education Program)
_____ Summer	July 31, 2015 (Freshman Summer Start Program)
_____ Fall	September 23, 2015
_____ Winter	January 3, 2016
_____ Spring	February 15, 2015

Insurance Plan Year 2015-2016

I understand by canceling my waiver that I will automatically be enrolled in GHI and am obligated to pay the insurance premium each quarter.

Name _____ Graduate _____ Undergraduate _____

Local Mailing Address _____

Perm Number _____

Signature _____ Date _____

STUDENT HEALTH SERVICE USE ONLY

Date of Cancellation _____ **Beginning Date of Coverage** _____

Insurance Advisor Signature _____ **Date** _____